Access To Mental and Behavioral Health Care for Students in K-12 Schools

A Report of the

Iowa Advisory Committee to the

U.S. Commission on Civil Rights

April 2025

Advisory Committees to the U.S. Commission on Civil Rights

By law, the U.S. Commission on Civil Rights has established an advisory committee in each of the 50 states and the District of Columbia. The committees are composed of state citizens who serve without compensation. The committees advise the Commission of civil rights issues in their states that are within the Commission's jurisdiction. They are authorized to advise the Commission in writing of any knowledge or information they have of any alleged deprivation of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, national origin, or in the administration of justice; advise the Commission on matters of their state's concern in the preparation of Commission reports to the President and the Congress; receive reports, suggestions, and recommendations from individuals, public officials, and representatives of public and private organizations to committee inquiries; forward advice and recommendations to the Commission, as requested; and observe any open hearing or conference conducted by the Commission in their states.

Acknowledgments

The Iowa Advisory Committee (Committee) would like to acknowledge the panelists, community members, others involved in providing testimony for this study. The Committee also wishes to thank Civil Rights Analyst Intern Angela M. Brown for her work supporting the drafting of this report.

Letter of Transmittal

Iowa Advisory Committee to the
U.S. Commission on Civil Rights

The Iowa Advisory Committee to the U.S. Commission on Civil Rights submits this report regarding access to mental and behavioral health care for students in K-12 Schools. The Committee submits this report as part of its responsibility to study and report on civil rights issues in the state. The contents of this report are primarily based on testimony the Committee heard during public meetings held via videoconference on April 18, 2024; May 23, 2024; May 30, 2024; and September 18, 2024. The Committee also includes related testimony submitted in writing during the relevant period of public comment.

This report begins with a brief background of the issues to be considered by the Committee. It then presents primary findings as they emerged from this testimony, as well as recommendations for addressing areas of civil rights concerns. This report is intended to focus on civil rights concerns regarding access to mental and behavioral health care for student in Iowa's K-12 schools on the basis of race, color, religion, sex, age, disability, and/or national origin. Specifically, the Committee sought to examine the extent to which specific state or local policies and practices may contribute to indicated disparities, as well as alternative practices or recommendations with the demonstrated potential to address such concerns. While additional important topics may have surfaced throughout the Committee's inquiry, those matters that are outside the scope of this specific civil rights mandate are left for another discussion.

Iowa Advisory Committee to the
U.S. Commission on Civil Rights

Juan Manuel Garcia, *Chair*, Waukee

Henry Hamilton, *Vice Chair*, West Des Moines

Kyle Burgason, Ames

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Katie Fiala, Johnston

Adam Freed, Urbandale

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* *See Appendix B for a Committee Member Statement*

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Overview

On November 16, 2023 the Iowa Advisory Committee (Committee) to the U.S. Commission on Civil Rights (Commission) adopted a proposal to undertake a study of access to mental and behavioral health care for K-12 students. The focus of the Committee's inquiry was to examine civil rights concerns regarding access to mental and behavioral health care for students in Iowa's K-12 schools on the basis of race, color, religion, sex, age, disability, and/or national origin. Specifically, the Committee sought to examine the extent to which specific state or local policies and practices may contribute to indicated disparities, as well as alternative practices or recommendations with the demonstrated potential to address such concerns. The Committee's initial questions for study at the outset included:

1. What are the barriers to access to mental health services for students?
2. Which programs are involved in providing services for students? Are these programs sufficiently funded? What other programs are potentially available?
3. Which populations are impacted by mental health concerns? How are they impacted?
4. Are there differences in access to mental health services regionally?

As part of this inquiry the Committee heard testimony via videoconference on April 18, 2024; May 23, 2024; May 30, 2024; and September 18, 2024.[1]

The Committee invited the following panelists to provide testimony during their hearings:

April 18, 2024 Web Hearing

- Jacob Priest, Associate Professor, Scanlan Center for School Mental Health
- Allan Eckelman, High School Counselor, Beckman Catholic High School
- Courtney Cook, President, Iowa School Counselor's Association
- Erin Lane, PhD., Vice President, Iowa School Counselor's Association

[1] Meeting records and transcripts are available here: https://usccr.box.com/s/zqmsldv7kpm1u0g1ystnatvbjdesi8kg. Briefing before the Iowa Advisory Committee to the U.S. Commission on Civil Rights, April 18, 2024, (web-based), Transcript (hereinafter cited as "*4/18/24 Web Hearing*"); Briefing before the Iowa Advisory Committee to the U.S. Commission on Civil Rights, May 23, 2024, (web-based), Transcript (hereinafter cited as "*5/23/24 Web Hearing*"); Briefing before the Iowa Advisory Committee to the U.S. Commission on Civil Rights, May 30, 2024, (web-based), Transcript (hereinafter cited as "*5/30/24 Web Hearing*"); Briefing before the Iowa Advisory Committee to the U.S. Commission on Civil Rights, September 18, 2024, (web-based), Transcript (hereinafter cited as "*9/18/24 Web Hearing*").

May 23, 2024 Web Hearing

- Karen Mackey, Director, Sioux City Human Rights Commission
- Kelly Garcia, Director, Iowa Department of Health and Human Services
- Renee Hardman, President and CEO, Lutheran Services in Iowa
- James Guentherman, Director of Clinical Services, Lutheran Services in Iowa

May 30, 2024 Web Hearing

- Anne Harris Carter, Health Equity Program Manager, Linn County Public Health
- Cindy Yelick, Chief Administrator, Heartland Area Education Agency
- Tami Valline, High School Counselor, Perry High School
- Tonya Hotchkin, Vice President of Clinical Prevention Services, Tanager Place

September 18, 2024 Web Hearing

- Debra A. Carr, LMSW, ACSW, CFSW, Student Services Coordinator, Des Moines Public Schools, speaking in a personal capacity
- Katie Issa, LISW, Behavior Health Services Coordinator, Des Moines Public Schools

The Iowa Advisory Committee had hoped to hear from students directly during their hearings. However, after recognizing the potential challenges of testifying publicly during their meetings, and recognizing that no students had participated in the hearings, the Iowa Advisory Committee developed an informal, voluntary survey and shared it with study participants to share with their networks for students to respond to if they wished.[2] There were 32 responses to the survey.[3] In addition, in the Federal Register notice for the Committee's October 17, 2024 meeting, the following note was published:

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[2] A survey link was made available to share with networks. The survey was open from October 1, 2024 through February 10, 2025 and the questions and related anonymous answers are available here: https://usccr.app.box.com/s/zqmsldv7kpm1u0g1ystnatvbjdesi8kg/file/1773972963651. Survey questions were also included in the Committee's Federal Register notice for interested students to respond to during the Committee's meeting: https://www.federalregister.gov/documents/2024/10/07/2024-23108/notice-of-public-meeting-of-the-iowa-advisory-committee-to-the-us-commission-on-civil-rights.

[3] Iowa Advisory Committee Survey 2/10/2025, at 1 (closed on February 10, 2025).

During public comment, students who wish to respond to the Committee's study are welcome to share any comments. Questions the Committee is considering include:

- Are you aware of mental health services in your school?
- If you or someone you know needed mental health services, would you know who to go to in your school?
- Would you be comfortable accessing mental health services through your school? If not, why not?
- If you have used mental health services in the past, have you found them helpful? If not, why not?
- Is there anything else you would like the Iowa Advisory Committee to the US Commission on Civil Rights to know about your experience with accessing mental and behavioral healthcare in Iowa's K-12 schools?

The following report results from a review of testimony provided at these meetings, combined with the student survey responses and written testimony submitted during this timeframe.

The report begins with a brief background on the issues to be considered by the Committee. It then identifies primary findings as they emerged from this testimony. Finally, it makes recommendations for addressing related civil rights concerns. This report focuses on access to mental and behavioral health care for students in Iowa’s K-12 schools. While other important topics may have surfaced throughout the Committee’s inquiry, matters that are outside the scope of this specific civil rights mandate are left for another discussion. This report and the recommendations included within it were adopted by a majority of the Committee on April 3, 2025.[4]

Background

Young people and their families have been facing significant mental health challenges for many years now, and the COVID-19 pandemic has only exacerbated these challenges, escalating the concern to a significant public health crisis. A 2021 report released by the United States surgeon general noted a doubling of depressive and anxiety-related symptoms among youth during the COVID-19 pandemic.[5] The American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association, which collectively represent over

[4] See Appendix B for Committee Member Statements.

[5] Office of the Surgeon General (OSG). Protecting Youth Mental Health: The U.S. Surgeon General’s Advisory. Washington (DC): US Department of Health and Human Services; 2021. PMID: 34982518.

77,000 physicians and over 200 children's hospitals, characterized the gravity of this situation as a "national emergency."[6]

Even before the pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people. According to the Centers for Disease Control (CDC), around 20 percent of children ages 3 to 17 in the U.S. reported a mental, emotional, developmental, or behavioral disorder.[7] In 2016, of the 7.7 million children with treatable mental health disorders, almost half did not receive adequate treatment.[8] The youth are significantly impacted as 1 in 5 children ages 13-18 have or will have a serious mental illness[9] and 50 percent of all lifetime cases of mental illness begin by age 14 and 75 percent by age 24.[10] In addition, the average delay between the onset of symptoms and intervention is 8-10 years[11] which has implications for educational attainment as approximately 50 percent of students who are 14 and older with a mental illness drop out of high school.[12]

As early as 2011, suicide became the second leading cause of death for youth ages 15-24 in the U.S. In 2014, suicide was the second leading cause of death for youth ages 10-14 in the U.S., though it dropped to the third leading cause in 2015.[13] When examining specific impacts across

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[6] "AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health," Oct. 19. 2021, https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/.

[7] Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., Hedden, S. L., Crosby, A. E., Visser, S. N., Schieve, L. A., Parks, S. E., Hall, J. E., Brody, D., Simile, C. M., Thompson, W. W., Baio, J., Avenevoli, S., Kogan, M. D., Huang, L. N., & Centers for Disease Control and Prevention (CDC) (2013). Mental health surveillance among children-United States, 2005-2011. MMWR. Morbidity and Mortality Weekly Report Supplements, 62(2), 1–35.

[8] Whitney, D.G. & Peterson, M. (2019). US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. JAMA Pediatrics, 173(4), 389–391. doi:10.1001/jamapediatrics.2018.5399.

[9] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005 Jun;62(6):593-602. doi: 10.1001/archpsyc.62.6.593. Erratum in: Arch Gen Psychiatry. 2005 Jul;62(7):768. Merikangas, Kathleen R [added]. PMID: 15939837.

[10] Ibid.

[11] Wang PS, Berglund PA, Olfson M, Kessler RC. Delays in initial treatment contact after first onset of a mental disorder. Health Serv Res. 2004 Apr;39(2):393-415. doi: 10.1111/j.1475-6773.2004.00234.x. PMID: 15032961; PMCID: PMC1361014.

[12] Data Resource Center for Child & Adolescent Health. (2005/2006). National Survey of Children with Special Health Care Needs. Portland, OR: The Child and Adolescent Health Measurement Initiative (CAHMI). childhealthdata.org/browse/survey/results?q=1099&r=1.

[13] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Jan 11, 2023 https://www.cdc.gov/injury/wisqars/LeadingCauses.html

genders, a recent report by the CDC examining emergency room visits for suspected suicide attempts among persons aged 12-25 years before and during the COVID-19 pandemic found that emergency room visits for suspected suicide attempts among girls increased more than 50 percent. The CDC also found the doubling of symptoms of anxiety and depression across genders.[14] In another study also conducted by the CDC examining trends on health behaviors and experiences among high school students in the United States related to adolescent health and wellbeing, for LGBTQ+ youth, they experience high levels of violence and mental health challenges where more than half (52 percent) of LGBTQ+ students had recently experienced poor mental health and that more than 1 in 5 (22 percent) attempted suicide in the past year.[15]

Iowa Youth and Mental and Behavioral Health

Data collected on Iowa youth and mental health concerns reflect similar trends to national data. As early as 2007, suicide has been the second leading cause of death for Iowa youth ages 15-24.[16] In a 2022 report from Mental Health America, 41,000 youth ages 12 to 17 in Iowa (16.7 percent) had at least one major depressive episode in the past year and about 32,000 youth (13.5 percent) were grappling with severe major depression in the past year. The report also estimated that about half of Iowa's youth with major depression did not receive mental health treatment.[17]

In 2021, over a two-month period there were five Polk County Iowa youth who died by suicide. The Iowa Department of Public Health, in partnership with Polk County public health officials, formally requested assistance from the CDC to study patterns and offer insight on how to respond.[18] In 2022, six juveniles have killed themselves. The 2021 Iowa Youth Survey reported

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[14] Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. MMWR Morb Mortal Wkly Rep 2021;70:888–894. DOI: http://dx.doi.org/10.15585/mmwr.mm7024e1external icon.

[15] Ibid.

[16] Iowa Department of Health and Human Services, Division of Public Health, Bureau of Health Statistics. 2021 Vital Statistics of Iowa. Des Moines: Iowa Department of Health and Human Services. Published 2023. Web. https://hhs.iowa.gov/health-statistics/data.

[17] Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA. https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf.

[18] Michaela Ramm, "A cluster of Iowa youth suicides worries health officials," *The Gazette*, Aug. 31, 2022. https://www.thegazette.com/iowa-ideas/the-canary-in-the-coal-mine/.

almost one in four 11th graders had thought about suicide in the past year.[19] Forty-nine percent of students who indicated they thought about ending their lives went so far as to make a plan.[20]

Iowa has eight child and adolescent psychologists per 100,000 residents younger than 18.[21] Eighty-six percent of Iowa's 99 counties lack a child psychiatrist.[22]

Methodology

As a matter of historical precedent, and in order to achieve transparency, Committee studies involve a collection of public, testimonial evidence and written comments from individuals directly impacted by the civil rights topic at hand; researchers and experts who have rigorously studied and reported on the topic; community organizations and advocates representing a broad range of backgrounds and perspectives related to the topic; and government officials tasked with related policy decisions and the administration of those policies.

Committee studies require Committee members to use their expertise in selecting a sample of panelists that is the most useful to the purposes of the study and will result in a broad and diverse understanding of the issue. This method of (non-probability) judgment sampling requires Committee members to draw from their own experiences, knowledge, opinions, and views to gain understanding of the issue and possible policy solutions. Committees are composed of volunteer professionals who are familiar with civil rights issues in their state or territory. Members represent a variety of political viewpoints, occupations, races, ages, and gender identities, as well as a variety of background, skills, and experiences. The intentional diversity of each Committee promotes vigorous debate and full exploration of the issues. It also serves to assist in offsetting biases that can result in oversight of nuances in the testimony.

In fulfillment of Committees' responsibility to advise the Commission of civil rights matters in their locales, Committees conduct an in-depth review and thematic analysis of the testimony received and other data gathered throughout the course of their inquiry. Committee members use this publicly collected information, often from those directly impacted by the civil rights topic of

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[19] Michaela Ramm, "'Does it have to be your kid?' Family calls out mental health system after teen's suicide'," *Des Moines Register*, Oct. 11, 2022, https://www.desmoinesregister.com/story/news/health/2022/10/11/iowa-teen-suicide-hotline-family-calls-out-mental-health-care/69541831007/

[20] Endres, Kyle, Ki Park, Mary E. Losch, Justine Radunzel & Erin O. Heiden. (2022). 2021 Iowa Youth Survey State Report. Cedar Falls, IA: Center for Social and Behavioral Research, University of Northern Iowa. https://iowayouthsurvey.idph.iowa.gov/Portals/20/IYS_Reports/1/ae0f13b7-8afd-49a8-9d87-84d2e0b846ab.pdf

[21] American Academy of Child & Adolescent Psychiatry. *Workforce Maps by State.* Available at: https://www.aacap.org/AACAP/Advocate/Policy_Resources/State_Workforce_Maps/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx?hkey=56cd4ca3-d496-4e93-82a9-ff19376b5ac9. Accessed December 30, 2024.

[22] Ibid.

study, or others with direct expert knowledge of such matters, to identify findings and recommendations to report to the Commission. Drafts of the Committee's report are publicly available and shared with panelists and other contributors to ensure that their testimony was accurately captured. Reports are also shared with affected agencies to request for clarification regarding allegations noted in testimony.

For the purposes of this study, **Findings** are defined as what the testimony and other data *suggested, revealed, or indicated* based upon the data collected by the Committee. Findings refer to a synthesis of observations confirmed by majority vote of members, rather than conclusions drawn by any one member. **Recommendations** are specific actions or proposed policy interventions intended to address or alleviate the civil rights concerns raised in the related finding(s). Where findings indicate a lack of sufficient knowledge or available data to fully understand the civil rights issues at hand, recommendations may also target specific directed areas in need of further, more rigorous study. Recommendations are directed to the Commission; they request that the Commission itself take specific action, or that the Commission forward recommendations to other federal or state agencies, policy makers, or stakeholders.

Findings

In keeping with their duty to inform the Commission of (1) matters related to discrimination or a denial of equal protection of the laws; and (2) matters of mutual concern in the preparation of reports of the Commission to the President and the Congress,[23] the Iowa Advisory Committee submits the following findings to the Commission regarding access to mental and behavioral health care for students in K-12 schools. This report seeks to highlight the most salient civil rights themes as they emerged from the Committee's inquiry. The complete meeting transcripts and written testimony received are included in the Appendix for further reference.

Finding I: There has been an increase in demand for mental health services in Iowa's K-12 schools since the COVID-19 pandemic.

The COVID-19 pandemic served as a cataclysmic event doubling the national number of people with behavioral health conditions from 20 percent pre-pandemic to 40 percent post-pandemic.[24] Kelly Garcia, Director of the Iowa Department of Health and Human Services, noted our regular health surveillance of Iowa students underscores these data points, demonstrating our students are

[23] 45 C.F.R. § 703.2 (2018).

[24] Garcia Testimony, *5/23/2024 Web Hearing*, p. 7, referring to data from Manderscheid, R. W., & Ward, A. A. (2024). Stepping into the future of behavioral health: Opportunities,

challenges, and possibilities. American Journal of Orthopsychiatry. Advance online publication. https://

dx.doi.org/10.1037/ort0000743.

indeed struggling, and increasingly complex and severe mental and behavioral health conditions.[25] Recent data reported 41 percent of female students, as compared to 20 percent of male students, report feeling sad or hopeless,[26] while 27 percent of female students indicated suicidal ideation compared to 14 percent of male students.[27] Debra A. Carr, Student Services Coordinator with Des Moines Public Schools, who shared testimony with the Committee in a personal capacity, stated that the population of students needing assistance is growing, with approximately one out of every five students experiencing some type of mental health problem during their school years.[28] She noted that the challenges she typically sees include anxiety, stress, and substance abuse.[29]

Allan Eckelman, High School Counselor at the Beckman Catholic High School, shared that while parents and community members are more likely to attribute higher rates of absences to physical illness, higher rates of absences during distress, anxiety, headaches, and the general ability to graduate or function in school result from mental health and psychological issues, especially post-COVID.[30] Cindy Yelick, Chief Administrator with Heartland Area Education Agency, noted the impact of technology upon mental health as a result of over-connectivity and cyberbullying, foregrounding ways employed to assist schools in implementing essential policies to protect children as well as teach kids about the appropriate use of technology. [31] Dr. Erin Lane, Vice President, Iowa School Counselor's Association, reinforced "behavior as communication," noting kindergartners throwing chairs across the room, elopements, as well as running around the school among first and second graders are a means of informing "the adults in the space that the children are not okay." Dr. Lane further testified this requires the need for a crisis management response with the presence of school counselors.[32]

Courtney Cook, President of the Iowa School Counselor's Association testified that although the increase in mental health services impacts all students in Iowa, it is aided by four barriers that disproportionately impact some students more than others.[33] These students are specifically "LGBTQ+ students, students of color, English language learners, students from low-income families, and youth with significant mental health diagnoses," who are at "heightened risk for

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[25] Ibid.

[26] Ibid.

[27] Ibid.

[28] Carr Testimony, *9/18/2024 Web Hearing*, p. 2.

[29] Ibid.

[30] Eckelman Testimony, *4/18/2024 Web Hearing*, p. 8.

[31] Yelick Testimony, *5/30/2024 Web Hearing*, p. 8.

[32] Lane Testimony, *4/18/2024 Web Hearing*, pp. 13-4.

[33] Cook Testimony, *4/18/2024 Web Hearing*, p. 6.

mental health challenges" and require consideration for their "unique social and cultural situations" to provide effective mental healthcare.[34]

She highlighted the following four barriers:

1. School counselors are being tasked with administrative duties such as monitoring study hall, recess, lunchroom, and standardized tests rather than having their time and skills reserved for the counseling role they are trained for;[35]

2. There is a lack of school counselors with specific training in child and adolescent development;[36]

3. There are logistical barriers to accessing mental health providers, such as significant wait lists, inadequate insurance coverage, or transportation issues;[37] and

4. There is a lack of state and local support for counseling services.[38]

Ms. Cook provided context on what current capacity looks like for the Committee, noting that the American School Counselor Association recommends an average of one counselor to every 250 students, but Iowa has an average of one counselor to every 353 students.[39] She noted that 92 out of Iowa's 99 counties are designated by the Iowa Department of Public Health as "mental health care shortage areas," and three-quarters of school counselors believe access to mental health care is difficult in Iowa.[40]

Finding II: Rural vs. urban school geographic location contributes to disparities in access, particularly for students based on race, ethnicity, LGBTQ+, and disability status.

While barriers accessing behavioral and mental health care impact all Iowans, issues are more acute in Northwest Iowa due to fewer providers and facilities, contributing to disparities in access among K-12 children in Sioux City.[41] Katie Issa, Behavior Health Services Coordinator with Des Moines Public Schools, noted that attendance impacts achievement and can be an indicator along with behavior, which requires looking at different indicators to understand root causes of mental

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[34] Ibid.

[35] Cook Testimony, *4/18/2024 Web Hearing*, p. 5.

[36] Ibid.

[37] Cook Testimony, *4/18/2024 Web Hearing*, pp. 5-6.

[38] Cook Testimony, *4/18/2024 Web Hearing*, p. 6.

[39] Ibid, p. 5.

[40] Ibid.

[41] Mackey Testimony, *5/23/2024 Web Hearing*, p. 3.

health issues and barriers to resolving those issues.[42] Among those barriers are transportation, including lack of public transportation with routes not mirroring need and impacted by funding cuts, as well as the lack of stable, affordable housing.[43] Compounding the challenge are the struggles of parents needing to take time off from work to take their children to appointments while contending with "adult stigma against mental health concerns."[44] Additionally, "logistical access to mental health providers" resulting from significant wait lists, inadequate insurance coverage, and a lack of state and local support for counseling services in their schools"[45] perpetuates the issues. The lack of a good internet connection also affects rural students.[46]

Karen Mackey, Director of the Sioux City Human Rights Commission, highlighted models that remove barriers to care such as delivering services on-site to limit time away from class by students and lift the burden of transportation from parents who have to work.[47] Examples include Siouxland Mental Health which saw 129 children in 2023 for a total of 837 therapy sessions, Sky Ranch behavioral health program which offers Anger Replacement Training program, and a partnership with Urban Native Center employing Elementary and Secondary School Emergency Relief funds[48] post-COVID.[49]

Finding III: Iowa has experienced significant demographic changes that present challenges in ensuring all student populations have access to appropriate, quality mental and behavioral health services.

Des Moines public schools currently have a "majority minority" population reflecting significant changes in demographics over the past 20 years.[50] This impacts access, underscoring the issue of

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[42] Issa Testimony, *9/18/2024 Web Hearing*, p. 5.

[43] Ibid., pp. 5-6.

[44] Lane Testimony, *4/18/2024 Web Hearing*, p. 6.

[45] Ibid.

[46] Guentherman Testimony, *5/23/2024 Web Hearing,* p. 13.

[47] Mackey Testimony, *5/23/2024 Web Hearing*, p. 4.

[48] Under ESSER, established in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136 (March 27, 2020), and further funded under the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act, 2021, Pub. L. No. 116-260 (December 27, 2020) and the American Rescue Plan (ARP) Act of 2021, Pub. L. No. 117-2 (March 11, 2021), the U.S. Department of Education (Department) awarded grants to State educational agencies (SEAs) for the purpose of providing local educational agencies (LEAs) that receive funds under part A of title I of the Elementary and Secondary Education Act of 1965 (ESEA), including charter schools that are LEAs, with emergency relief funds to address the impact the COVID-19 pandemic has had, and continues to have, on elementary and secondary schools across the Nation." See https://www.ed.gov/sites/ed/files/2022/12/ESSER-and-GEER-Use-of-Funds-FAQs-December-7-2022-Update-1.pdf, p. 2.

[49] Ibid.

[50] Carr Testimony, *9/18/2024 Web Hearing*, p. 3.

inequity and disparities as Black and other marginalized students struggle to identify supportive services to help them navigate mental and behavioral health challenges.[51]

The Iowa Advisory Committee developed a survey to help ascertain the student experience and shared the survey with study participants and through the Federal Register.[52] The Committee received 32 responses from students.[53] Participants voluntarily offered their demographic information (see Figures 1, 2, and 3) and answered six questions related to accessing mental and behavioral health services.

Half of the participants identify as female, 44 percent of participants identify as male, and 6 percent declined to answer. When narrowing down by racial and ethnic background, one third of participants identify as White. Other survey respondents identified as American Indian or Alaska Native (13 percent), Asian (6 percent), Black or African American (22 percent), Native Hawaiian or other Pacific Islander (16 percent), and two or more races (9 percent). There were no responses from students who identify as Hispanic or Latino.

Figure 1 stratifies the data further and shows racial and ethnic background by sex of survey participants.

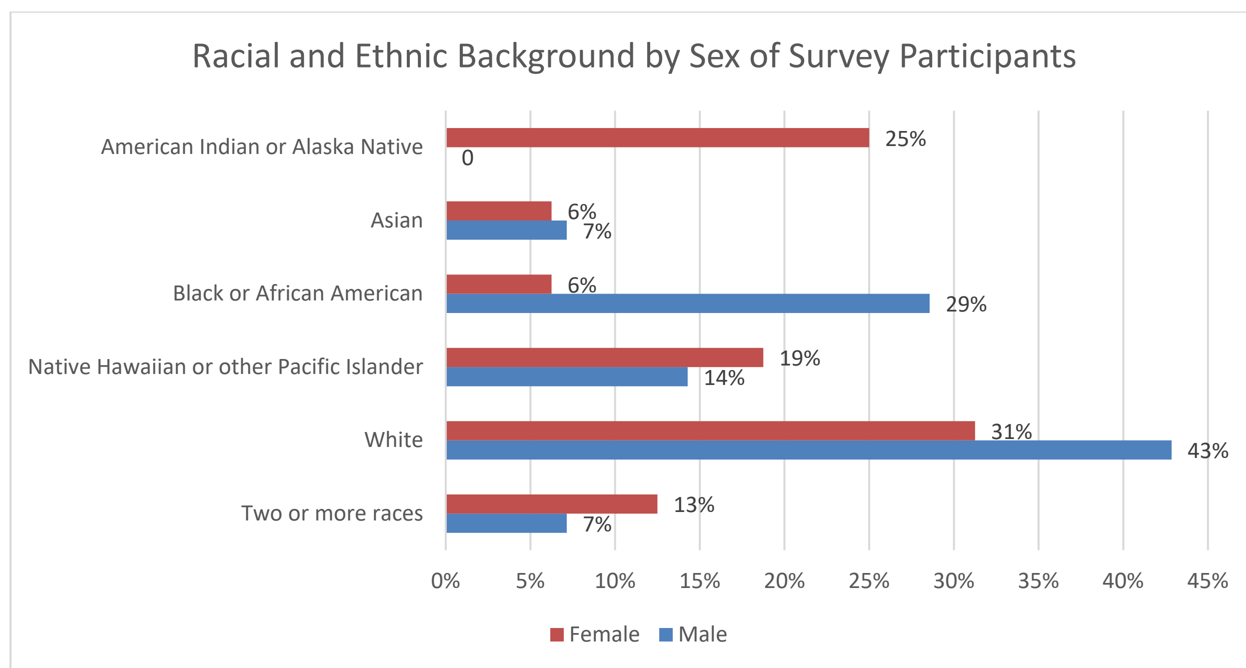

Figure 1

[51] Ibid.

[52] See page 5 for survey questions.

[53] Iowa Advisory Committee Survey 2/10/2025, at 1. The survey responses laid out in this report are purely descriptive in nature and do not make any inference to any particular hypothesis.

Seventy-two percent of survey participants identify as heterosexual, 6 percent identify as LGBTQ+, and 22 percent declined to answer.

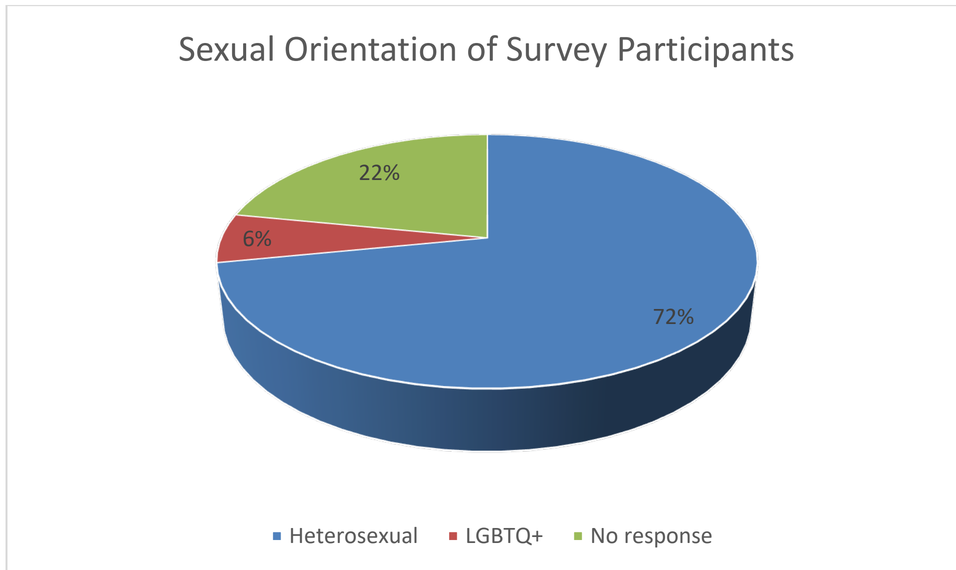

Figure 2

Participants also shared the setting of their school's location. Nearly half of students who responded attend a school in a rural area of the state, 41 percent attend a school in an urban area, and 13 percent declined to answer.

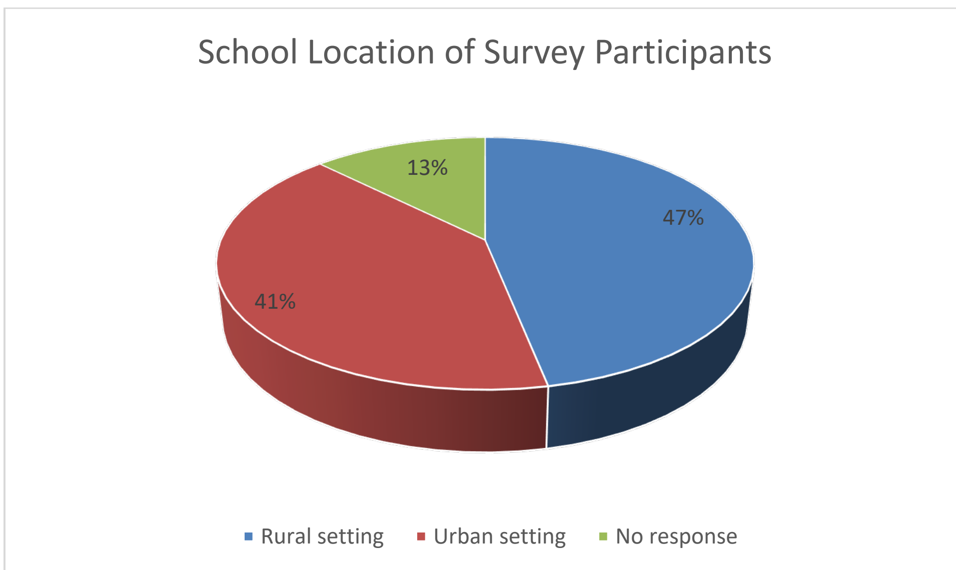

Figure 3

When asked if they are aware of mental health services in schools, 63 percent of survey participants stated they were aware, 34 percent said they were not aware, and 3 percent declined to answer. In a similar question related to awareness of services for someone who needed mental health services,

roughly 60 percent of students responded that they knew who to contact, while 34 percent did not know, and 6 percent declined to answer.

Students also responded to a hypothetical question about whether they were comfortable with accessing mental and behavioral health services through school. Half of students responded that they would be comfortable with accessing services, 47 percent said no, and 3 percent declined to answer. Those students who would not be comfortable accessing services shared several reasons: they were not sure who to trust, uncomfortable with accessing services, have a non-school resource, prefer to talk to their friends, prefer to keep some things to themselves to avoid "everyone in [their] business," and that these services were not discussed in school. Additionally, 53 percent who accessed mental health services found them to be helpful, while 41 percent did not find the services helpful, and 6 percent declined to answer.

Students offered additional responses to their experience with accessing mental and behavioral health care in Iowa schools and any information they would like to share with the Committee. A male student, who identifies as White, shared a positive perspective and stated that he was aware of resources in his K-8 years and continually worked to keep abreast of school mental health services. He said,

> "While I continued to struggle with my own mental health, I always felt supported by the school faculty and staff. The school supported me with accommodations, interpersonal support, and accessible resources for mood-related episodes. I always felt seen and cared for by the staff and faculty at [my high school], even when I didn't feel it from my fellow classmates."[54]

One female student, who identifies as Asian said,

> "I would love to see individuals in K-12 schools who are qualified/licensed to provide mental health services, or at least people who seem to care about all their students. I had one guide counselor who did not care about most of the students and was pretty much only there to make class schedules and hang out with the boys. It was kind of unnerving (as a girl). Even a person with a bachelor's degree could probably suffice." [55]

Another female student, who identifies as White noted, "I wish it were easier to access mental health services outside of school with all insurance types. More counselors per student ratios would drastically help connect students with services."[56]

Several students also said that school is hard. Others would like to be listened to more and that teachers do not help or understand students.[57]

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[54] Iowa Advisory Committee Survey 2/10/2025, at 1

[55] Ibid.

[56] Ibid.

[57] Ibid.

Finding IV: Interpersonal, institutional, and structural barriers yield inequities disproportionately affecting students based on race, ethnicity, LGBTQ+, and disability status.

Renee Hardman, President and CEO of Lutheran Services (LSS) in Iowa, noted that while her agency serves a broad population, racial and ethnic minorities consistently have less access to mental health services.[58] She noted that there are a disproportionately high number of Black youths in foster care resulting in higher rates of Black youth affected by mental and behavioral health issues, with 40 percent of teenagers LSS serves having some type of mental health challenge.[59]

Karen Mackey, Director of the Sioux City Human Rights Commission described the local school district in Sioux City which as "made up of over 57 percent racial and ethnic minorities" in a blue-collar community where many people perform "line work" making it "very difficult for parents to take time off work to address their children's mental or behavioral health issues."[60] Structural inequities such as limited state funding for mental health providers and services which is dictated by property taxes further contribute to this disparity.[61] This is in addition to policies and procedures that have caused concern among administrators and teachers who don't want to be perceived as positioning one group's needs over the other.[62] Anne Carter, Health Equity Program Manager with Linn County Public Health, shared that Linn County's 2020 position statement on racism as a public health crisis following the murder of George Floyd propelled creation of Office of Health Equity and the advent of a health equity work group to "remove barriers and create solutions" for addressing racial and ethnic disparities in health.[63] Effectively addressing these disparities requires understanding the implications of race on health, as well as institutional, structural, and internalized interpersonal racism upon disparities in access and care, and "understanding of what impact racism has upon mental wellbeing and how the local healthcare system can provide culturally informed care and promote social belonging."[64]

Ms. Carter noted that her workgroup in Linn County conducted informal interviews with 49 individuals who were contacts of their workgroup members to gain an understanding of their community's experience regarding health in order to inform efforts to educate and eliminate structural barriers to access health care:[65]

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[58] Hardman Testimony, *5/23/2024 Web Hearing*, p. 11.

[59] Ibid.

[60] Mackey Testimony, *5/23/2024 Web Hearing*, p. 3.

[61] Carr Testimony, *9/18/2024 Web Hearing*, pp. 3-4.

[62] Ibid.

[63] Carter Testimony, *5/30/2024 Web Hearing*, p. 4.

[64] Ibid., p. 5.

[65] Ibid., p. 6.

Figure 4: Carter Slides, 5/30/2024 Web Hearing, at 13.

From their informal interviews regarding whether respondents were comfortable seeking help, informed about where to go, and comfortable with providers, Ms. Carter noted that her workgroup learned about the need to map community-based services that center cultural-competency in providing health care (Figures 2 and 3).[66]

[66] Carter Testimony, *5/30/2024 Web Hearing*, p. 7.

Next Steps: *What demonstrates a space is* ***expressly*** *created to eliminate the impact of structural racism?*

Summer 2024

- Map community-based services in metro area
- Investigate behavioral health delivery models that center culturally informed care

Fall 2024

- Partner with Coe College research team
- Prioritize opportunities in clinical/community settings
- Establish short-term implementation plan

Spring 2025

- Complete long-term strategic plan

Figure 5: Carter Slides, 5/30/2024 Web Hearing, at 13.

Debra A. Carr, Student Services Coordinator with Des Moines Public Schools shared that inequities in access maintain a correlation with disproportionately higher rates of suspensions and expulsions, with Black students representing 6 percent of the student body but 24 percent of suspensions.[67] This demonstrates some children are punished more harshly than others, reflecting implicit bias.[68] Jacob Priest, Associate Professor at the Scanlan Center for School Mental Health underscored the "down river" effects of policies and structures created with emphasis on addressing root causes of "children in the river," particularly LGBTQ+ youth and youth who are non-binary.[69] According to the Trevor Project, 45 percent of LGBTQ youth seriously considered attempting suicide in the past year and 60 percent of LGBTQ youth who wanted mental health care in the past year were not able to get it.[70] Marginalized populations, including students with disabilities, LGBTQ+ populations, and students and families with language barriers are disproportionately impacted by racial and ethnic discrimination and implicit bias.[71] LGBTQ+,

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[67] Carr Testimony, *9/18/2024 Web Hearing*, p. 3.

[68] Ibid.

[69] Priest Testimony, *4/18/2024 Web Hearing*, p. 10.

[70] The Trevor Project, "2022 National Survey on LGBTQ Youth Mental Health," 2022, https://www.thetrevorproject.org/survey-2022/.

[71] Issa Testimony, *9/18/2024 Web Hearing*, p. 6.

including trans and non-binary kids, struggle to access mental health interventions over fear of being "outed" to their parents.[72]

There are often waiting lists of three to six months or longer for placements in psychiatric mental health institutions for children.[73] In the absence of acute inpatient mental health services for children, with the closest acute inpatient services at least 90 miles away in either Omaha, Nebraska or Sioux Falls, South Dakota, most children are sent more than 200 miles away for treatment, making parental involvement even more challenging.[74] Ms. Mackey shared,

> "I am a member of Siouxland Pride Alliance, and in 2023, we increased our youth support group from meeting once a month to meeting weekly. The children were so traumatized by the legislative attack on their very existence, and subsequently then being targeted by their classmates and bullied, that their mental health suffered, and it really continues to suffer. We have been meeting with these children now weekly for two years. We had one recently that we were just trying to get them through the school year, because they were expressing suicidal ideations, because it was so traumatizing just to go to school. Those children are suffering. They need all of our help, and they need the legislature to quit attacking them."[75]

Further, the lack of streamlined screening and assessment processes and provider cultural competence threatens access due to the lack of diversity amongst providers while marginalized populations, i.e., racial and ethnic minorities and LGBTQ+ communities, are disproportionately affected.[76]

Finding V: Changing demographics in Iowa expose a need for culturally specific, child-centered trauma approaches to care to prevent disparities in access to care.

Despite changing demographics in the state, nearly 97 percent of the teaching and counseling workforce is white and lacking cultural awareness, misunderstanding unique challenges of trauma and appropriate symptoms of it and responses to it.[77] As a consequence, Cindy Yelick, Chief Administrator with Heartland Area Education Agency, noted that she has witnessed the emergence of accessing law enforcement by schools to deescalate a student in crisis or transport to a local emergency room and the trauma this imposes upon the student and their family.[78] Ms. Carr shared

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[72] Priest Testimony, *4/18/2024 Web Hearing*, p. 9.

[73] Mackey Testimony, *5/23/2024 Web Hearing*, p. 5.

[74] Ibid.

[75] Mackey Testimony, *5/23/2024 Web Hearing*, p. 5; e.g., HF 190 Removes gender identity as a class from the Iowa Civil Rights Act, https://www.legis.iowa.gov/legislation/BillBook?ga=90&ba=hf190.

[76] Hotchkin Testimony*, 5/30/2024 Web Hearing,* pp. 19-20.

[77] Carr Testimony, *9/18/2024 Web Hearing*, p. 3.

[78] Yelick Testimony, *5/30/2024 Web Hearing*, p. 11.

that the lack of culturally competent mental health service providers in Iowa propels a need to build a pipeline and address policy change.[79] Ms. Carter said,

> "there's probably not an overnight fix for anything, but one of my fears is that we don't invest enough time, energy, and money in equipping the majority population to understand experiences that may be completely unfamiliar to them. And that's what we hear over and over again in our work group. Whether it's bias or implicit bias or microaggressions, the attitude is I'm used to it, this is just the way life is. But that creates stress. And so I would really love a solution that also helps our majority providers' experiences."[80]

Parents who lack education about mental health and available resources for their children as many students are the first in their family to graduate high school impose additional barriers.[81] Cultural and language barriers on access warrant need for more bilingual therapists, specifically Spanish-speaking therapists, noting there was only one bilingual therapist hired to serve the entire district with a high school population of 600 students of which more than 50 percent are Latino.[82]

However, Tonya Hotchkin, Vice President of Clinical Prevention Services at Tanager Place, shared that bias in standardized testing is geared towards Caucasian people, impeding the licensure of other populations who could be incredibly healing and transformative, and are culturally the same identity as many of the populations needing these services.[83]

Licensing is particularly relevant in ensuring there is a diverse workforce of trained professionals. In a working paper reviewing licensure exams authored by researchers at California State University Northridge and University of Washington, Benjamin E. Caldwell and Tony Rousmaniere they found,

> "After more than 50 years of use, there remains no evidence that clinical exams in mental health care improve the quality or safety of that care. Absent such evidence, our reliance on these exams is built on trust, from professionals, policymakers, and the public…With ample evidence of racial disparity in exam performance, credible and longstanding criticisms that have not been adequately addressed, and potential conflicts of interest among boards serving as both exam buyers and sellers, that trust is not deserved."[84]

In a similar examination of potential factors that influence the pass rates for licensing exams, providing disability accommodation becomes a determining factor:

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[79] Carr Testimony, *9/18/2024 Web Hearing*, p. 3.

[80] Carter Testimony, *5/30/2024 Web Hearing*, p. 22.

[81] Valline Testimony, *5/30/2024 Web Hearing*, p. 12.

[82] Ibid.

[83] Hotchkin Testimony, *5/30/2024 Web Hearing*, p. 25.

[84] Benjamin E. Caldwell PsyD, Tony Rousmaniere PsyD, and Association of Social Work Boards, "Clinical Licensing Exams in Mental Health Care," 2022, p.3, https://www.psychotherapynotes.com/wp-content/uploads/2022/10/Clinical-Licensing-Exams-in-Mental-Health-Care-October-2022.pdf.

> "Inadequate disability accommodations were identified as one of the most significant predictors of passing the exam. These findings suggest that the exam testing sites may not be providing adequate accommodations for those with disabilities, which is concerning. The American Association of Marriage and Family Therapy Regulatory Boards and Board of Behavioral Sciences should do further investigation to determine how best to meet the needs of test-takers with disabilities."[85]

Additionally, Ibrahim Kendi, researcher at Boston University at the Antiracist Research & Policy Center commented on the weight of standardized tests:

> [T]oday, many Americans still imagine an achievement gap rather than an opportunity gap. We still think there's something wrong with the kids rather than recognizing the[re is] something wrong with the tests. Standardized tests have become the most effective racist weapon ever devised to objectively degrade Black and Brown minds and legally exclude their bodies from prestigious schools.[86]

Ms. Yelick further commented on the lack of culturally competent providers resulting in significant gaps in service, including 230 students in one school district who were in need of individualized care with no local providers.[87] Ms. Carr voiced a need for a new curriculum and culturally sensitive, child-centered approaches to care reflective of communities in response to rise of new Iowans that require sensitivity to non-Eurocentric worldviews.[88] Ms. Cook noted there is a need for school counselors who can provide age-appropriate social emotional skills lessons.[89] However, Allan Eckelman, High School Counselor at the Beckman Catholic High School noted that financial constraints impede appropriate staffing levels.[90]

Finding VI: A lack of school counselors dedicated to exclusively providing mental health care where it's most needed exacerbates current challenges in providing mental and behavioral health care to K-12 students in Iowa.

According to Courtney Cook, President, Iowa School Counselor's Association, "school counselors are often not allowed to work to the highest level of their counseling license" to provide "youth mental health prevention and intervention services in schools" [because] "master's level school counselors are regularly asked to take on substitute teaching and administrative assistant duties,

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[85] Lyness, K., Gehart, D., Hannigan, B. et al. Licensing Exam Pass Rate Disparities in Marriage and Family Therapy: Using an Analysis of Predictive Factors to Inform a More Equitable Licensing Exam Process. Contemp Fam Ther (2025). https://doi.org/10.1007/s10591-024-09729-5

[86] Boston Coalition Education Equity, "Read Ibram X. Kendi's Testimony in Support of the Working Group Recommendation to #SuspendTheTest — Boston Coalition for Education Equity," Boston Coalition for Education Equity, October 22, 2020, https://www.bosedequity.org/blog/read-ibram-x-kendis-testimony-in-support-of-the-working-group-recommendation-to-suspendthetest.

[87] Yelick Testimony, *5/30/2024 Web Hearing*, p. 26.

[88] Carr Testimony, *9/18/2024 Web Hearing*, p. 4.

[89] Cook Testimony, *4/18/2024 Web Hearing*, p. 14.

[90] Eckelman Testimony, *4/18/2024 Web Hearing*, p. 15.

rather than the role they are uniquely prepared to do."[91] She further reported that "the lack of school counselors and mental health providers specializing in child and adolescent development" serves as a secondary barrier, noting average caseload of "one counselor to every 353 students" for school counselors in Iowa.[92] Ms. Cook defined the role of today's school counselor as "data-driven, evidence-based counselors who work on prevention and intervention within the school setting" and are "prepared to support all K-12 students holistically, with academic, post-secondary, social and emotional development and issues."[93] Compared ideal role of school counselor to that of "primary care provider" noting school counselors are on front line of youth mental health crisis in the state."[94]

According to a 2021 state-administered survey of youth in Iowa, 27 percent of sixth graders, 29 percent of eighth graders, and 36 percent of 11th graders reported feeling so sad or hopeless almost every day for two weeks or more in a row.[95] Additionally, almost 11 percent of youth ages three to 17 in Iowa have anxiety concerns with 24 percent, or nearly a quarter of 11th graders in Iowa reporting to have considered suicide in the past 12 months.[96]

Citing data conducted by Iowa School Counselors Association reporting, Dr. Lane, Vice President, Iowa School Counselor's Association noted "three quarters of respondents indicate that they feel the mental health services they provide are not as valued by the state" and "three quarters of Iowa school counselors perceived their job as more difficult than it was, prior to the passing of educational reforms in the 2023 Iowa Legislative Session."[97] Describing a tiered system of supports for kids in pre-k through high school graduation, Ms. Yelick testified the system is not positioned to work with families or provide direct support to parents of students, so efforts are aimed at teachers and school structures to build inclusive classrooms.[98] Tami Valline, High School Counselor at Perry High School, noted that she has experienced a school shooting, and stressed need to address mental and emotional needs of staff and students.[99]

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[91] Cook Testimony, *4/18/2024 Web Hearing*, p. 5.

[92] Ibid.

[93] Ibid., p. 3.

[94] Lane Testimony, *4/18/2024 Web Hearing*, p. 4.

[95] Lane Testimony, *4/18/2024 Web Hearing*, p. 4, referring to the 2021 Iowa Youth Survey Special Topics Report: Mental Health Findings, at 10: https://publications.iowa.gov/46682/1/2021_IYS_MHReport_Final_03_01_2022_0.pdf

[96] Ibid.

[97] Lane Testimony, *4/18/2024 Web Hearing*, p. 6.

[98] Yelick Testimony, *5/30/2024 Web Hearing*, pp. 8-9.

[99] Valline Testimony, *5/30/2024 Web Hearing*, p. 12.

Finding VII: Inadequate funding restricts access to mental and behavioral health resources in educational settings.

James Guentherman, Director of Clinical Services with Lutheran Services in Iowa, shared that there is underfunding in educational settings, which is resulting in long wait times, insufficient staffing, and lack of resources that can meet the growing demand.[100] Dr. Lane proposed solutions for state and federal government consider that could alleviate youth mental health challenges:

- Continuing to fund Elementary and Secondary School Emergency Relief on the federal level;

- Earmarking funding specifically for mental health resources with an emphasis on recruiting and retaining counselors with diverse identities and experiences and those who want to work in rural settings;

- Requiring social, emotional and mental health preventative skills to be taught K-12 in schools at the state level, including trauma, crisis and mental health interventions specific to youth as part of core curriculum in school counseling preparation programs;

- Repealing or amending Iowa's Senate File 496,[101] due to reports from counselors that the bill has created unnecessary challenges regarding critical preventative care and short-term interventions.[102]

While the Iowa legislature has approved a series of grants to fund the creation of therapeutic classrooms across the state set up in collaboration between a school district and Area Education Agencies, it was not examined systemically before implementation, creating pockets where some students have access to social-emotional supports that is out of reach to others.[103]

Payer source for most children in Iowa is Medicaid, requiring historic-level increases in behavioral health rates as endorsed by the legislature, a key component of ensuring access across the state.[104] This warrants a redesign of the waiver system in the Medicaid program as service packages are not meeting the needs of Iowans today, shifting from diagnosis-based, to needs-based waiver.[105] Additionally, Elementary and Secondary School Emergency Relief funding is ending in spite of

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[100] Guentherman Testimony, *5/23/2024 Web Hearing*, p. 12.

[101] 2023 Iowa Acts, Senate File 496, https://www.legis.iowa.gov/docs/publications/LGE/90/SF496.pdf.

[102] Lane Testimony, *4/18/2024 Web Hearing*, pp. 7-8.

[103] Yelick Testimony, *5/30/2024 Web Hearing,* pp. 9-10.

[104] Garcia Testimony, *5/23/2024 Web Hearing*, p. 9.

[105] Ibid.

its efforts to address staffing shortfall to fund behavioral specialist positions.[106] In response, places like Sky Ranch are piloting programs to fund positions in two of three middle schools to support at-risk children with academic, social, and behavioral needs via the Beyond the Bell after-school program.[107]

Nonetheless, few mental health-related resources in the community of Dyersville persist, with most in Dubuque which is 25 miles away.[108] While a network exists, it is void of a true continuum of supports for all kinds of student needs, and gaps in services as providers are either not available, accessible, or affordable by all Iowans, especially those who are poor are living in rural areas.[109] There are rural challenges including impediments of internet connection which are compounded by lack of attention span by students.[110] In response to the shortage of providers in rural Iowa, Mr. Guentherman noted that he works to hire school social workers that can be shared across school districts once or twice a week to offer immediate support from a school social worker and help them access community resources if those resources are present.[111] To further address this gap in service, Allan Eckelman testified that Beckman Catholic High School has signed a contract with an agency in Dubuque to provide the services of a mental health-related, on-site therapist two days per week providing "individual appointments, some weekly, some bi-weekly, to up to five students at a time, and some group counseling sessions with five to 10 members."[112] The therapist serves four other elementary schools on the other days of the week.[113] Lastly, telehealth is an option for those comfortable with utilizing online support although many prefer in-person although the lack of internet access can pose challenges in some rural communities.[114] However, none of these options can replace the value of school counselors who can provide age-appropriate social emotional skills lessons,[115] but this is often impeded by financial restraints yielding staff reductions.[116]

[106] Mackey Testimony, *5/23/2024 Web Hearing*, p. 4.

[107] Ibid.

[108] Eckelman Testimony, *4/18/2024 Web Hearing*, p. 8.

[109] Yelick Testimony, *5/30/2024 Web Hearing*, p. 11.

[110] Guentherman Testimony, *5/23/2024 Web Hearing,* p. 13.

[111] Yelick Testimony, *5/30/2024 Web Hearing*, p. 9.

[112] Eckelman Testimony, *4/18/2024 Web Hearing*, pp. 8-9.

[113] Ibid.

[114] Valline Testimony, *5/30/2024 Web Hearing*, p. 13.

[115] Cook Testimony, *4/18/2024 Web Hearing*, p. 14.

[116] Eckelman Testimony, *4/18/2024 Web Hearing*, p. 15.

Finding VIII: Inadequate funding undermines workforce development and appropriate infrastructure that is essential to effectively address the existing and increasing provider shortages.

Retirees and those moving to pursue opportunities in other states compound the challenge, creating a substantial void in the workforce.[117] Cuts to Title XIX of the Social Security Act (Medicaid)[118] reimbursements by 25 percent in Iowa contribute to this reality, resulting in only three pediatricians and one part-time child psychiatrist for the entire Sioux City metropolitan area.[119] Mr. Guentherman testified that there's only one licensed therapist for every 500 individuals, noting the challenges kids face in accessing care as many licensed therapists only focus on adult services.[120] To address the shortage in providers, Kelly Garcia, Director of the Iowa Department of Health and Human Services proposed bringing a new provider to Iowa that serves incredibly complex needs and launching a specialized rate for this higher level of care in a Psychiatric Medical Institutions for Children setting,[121] while Ms. Valline suggested engaging retired people to volunteer to overcome the hurdle of funding that impedes hiring mental health therapists or social workers as part of the school staff.[122]

Finding IX: Inadequate funding impedes data collection that would help define current needs and spur innovative solutions.

The funding and structure of Area Education Agencies has changed significantly as a result of the last legislative session restricting "what's appropriate to teach in a social-emotional learning continuum," and how supports can be accessed.[123] Large wait lists and high co-pays further complicate the issue,[124] posing significant barriers based on the types of insurance providers accept, as well as the high volume of denials or slow authorizations by insurance providers.[125] Tonya Hotchkin, Vice President of Clinical Prevention Services at Tanager Place, highlighted resources utilized to address gaps in services, such as the Scanlan Center for School Mental Health, for up-to-date evidence-based mental health interventions that school counselors can use and Mobile Crisis Units "when students are actively experiencing a mental health crisis and need additional assessment and transportation to facilities where they can access immediate care,"

[117] Mackey Testimony, *5/23/2024 Web Hearing*, p. 3.

[118] 42 U.S.C. § 1396.

[119] Ibid.

[120] Guentherman Testimony, *5/23/2024 Web Hearing*, p. 12.

[121] Garcia Testimony, *5/23/2024 Web Hearing*, p. 10.

[122] Valline Testimony, *5/30/2024 Web Hearing*, p.13.

[123] Yelick Testimony, *5/30/2024 Web Hearing*, p. 11.

[124] Valline Testimony, *5/30/2024 Web Hearing*, p. 12.

[125] Hotchkin Testimony, *5/30/2024 Web Hearing,* p. 17.

noting these services are managed regionally and are dependent on the organization and providers in the area.[126]

Recommendations

Among their duties, advisory committees of the Commission are authorized to advise the Agency (1) concerning matters related to discrimination or a denial of equal protection of the laws under the Constitution and the effect of the laws and policies of the Federal Government with respect to equal protection of the laws, and (2) upon matters of mutual concern in the preparation of reports of the Commission to the President and the Congress.[127] In keeping with these responsibilities, and given the testimony heard on this topic, the Committee submits the following recommendations to the Commission:

1. The U.S. Commission on Civil Rights should:

    a. Consider studying the civil rights concerns relating to state legislative social emotional learning curriculum restrictions that can devalue mental health professions and have significant impacts upon students based on race, ethnicity, socioeconomic status, and sexual orientation. Included in this study, the Commission should also review states' data collection and dissemination efforts to measure the scope and scale of the mental health concerns impacting K-12 students.

    b. Examine the immediate and long-term implications of involving law enforcement to intervene at schools when students experience mental and behavioral health services.

    c. Study the impact of technology upon mental health that is resulting in anxiety due to connectivity and cyberbullying among young people.

2. The U.S. Commission on Civil Rights should issue the following recommendations to the President and Congress to:

    a. Continue Elementary and Secondary School Emergency Relief Fund (ESSER) earmarking resources specifically for mental health resources to address increase in demand post COVID.

    b. Fund efforts to broaden digital access, ensuring rural communities can equitably benefit from telehealth services.

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[126] Lane Testimony, *4/18/2024 Web Hearing*, p. 7.

[127] 45 C.F.R. § 703.2 (2018).

c. Fund efforts to prepare future school counselors and mental health providers, with a particular focus on recruiting and retaining counselors who are interested in working in rural settings and have diverse identities and experiences.

d. Direct data collection and dissemination efforts across applicable federal agencies to measure the scope and scale of the mental health concerns impacting K-12 students.

3. The U.S. Commission on Civil Rights should issue the following recommendations to the U.S. Department of Health & Human Services and Centers for Medicare and Medicaid Services to:

    a. Develop a national clearinghouse of best practices in ensuring equitable access to mental and behavioral health for K-12 students for states and local school districts to refer to and ensure that there are ongoing efforts to keep this information current and relevant. Best practices should include how to include student and parent voices in access discussions.

    b. Review insurance fee, service structure, volume of denials, and slow authorizations of state contracts, comparing and contrasting state contracts with private insurance providers to understand barriers to mental and behavioral health treatments.

    c. Redesign the waiver system in the Medicaid program shifting from diagnosis-based to needs-based waiver as service packages are not meeting current mental and behavioral health needs.

    d. Examine Medicaid Title XIX tuition reimbursement options to help make Iowa, particularly rural areas in Iowa, more attractive to the mental health workforce.

    e. Create data collection and dissemination efforts to measure the scope and scale of the mental health concerns impacting K-12 students.

4. The U.S. Commission on Civil Rights should issue the following recommendations to the Iowa Legislature to:

    a. Fund efforts to increase the number of future school counselors and mental health providers, with a particular focus on recruiting and retaining counselors who are interested in working in rural settings and have diverse identities and experiences who students will feel comfortable speaking with.

    b. Review current standardized tests for clinicians as part of increasing the workforce, examining potential bias and adjusting as necessary to address impediments to licensure amongst potential nonwhite clinicians.

c. Increase funding to Iowa's Area Education Agencies and schools to recruit, hire, orient, and retain culturally competent school counselors exclusively dedicated to providing micro-level interventions at school and other community-based settings for Iowa's K-12 students in need of acute mental and behavioral health services.

d. Examine the state of funding that addresses health disparities and access to health care, and if deemed inadequate, consider increasing funding.

e. Require social, emotional and mental health preventative skills to be taught K-12 staff and teachers in schools, including trauma, crisis and mental health interventions specific to youth as part of core curriculum in school counseling preparation programs.

f. Ensure that all students have access to critical preventative care and initial short-term interventions in schools.

g. Direct Iowa's Area Education Agencies to develop robust data collection methods for tracking student needs based on relevant demographic factors.

h. Pass legislation to strengthen data collection and dissemination efforts across applicable state agencies to measure the scope and scale of the mental health concerns impacting K-12 students.

5. The U.S. Commission on Civil Rights should issue the following recommendations to the Iowa Department of Health and Human Services to:

    a. Increase availability of inpatient services for Iowa's K-12 students from rural communities and in need of acute and/or chronic mental and behavioral health services bringing a new provider to Iowa that serves incredibly complex needs and launching a specialized rate for this higher level of care in a Psychiatric Medical Institutions for Children setting.

    b. Develop workgroups to examine equitable access in mental and behavioral health in Iowa's K-12 schools, including students and parents who are open to participating.

    c. Create data collection and dissemination efforts to measure the scope and scale of the mental health concerns impacting K-12 students.

Appendices

Appendix A: Project Materials

Appendix materials related to this study can be found here:
https://usccr.box.com/s/zqmsldv7kpm1u0g1ystnatvbjdesi8kg

A. Project Materials
    a. Transcript
    b. Agenda
    c. Minutes
    d. Panelist Slides
    e. Written Testimony
    f. Survey Responses

Appendix B: Committee Member Statement

Stefanie Munsterman
Statement in Response to the 2025 Iowa Advisory Committee Report
Access to Mental and Behavioral Health Care for K-12 Students

I, Stefanie Munsterman (she/her), respectfully submit this statement in response to the findings and recommendations outlined in the 2025 report, *Access to Mental and Behavioral Health Care for Students in K-12 Schools*, issued by the Iowa Advisory Committee to the U.S. Commission on Civil Rights.

I commend the Committee for its diligent efforts in compiling critical data and for its intention to offer meaningful recommendations to address the significant barriers Iowa's youth face in accessing mental and behavioral health care. I am also deeply grateful for the opportunity to engage with and contribute to the advancement of this vital area of work.

While the report endeavors to address several critical challenges faced by youth in Iowa, it is imperative to highlight the recommendations are insufficient in addressing the unique and urgent needs of marginalized student populations, particularly the LGBTQIA community. In light of this, I must respectfully dissent from the conclusion that the report's recommendations adequately meet the pressing needs of all students I assert, with conviction, that the report fails to provide the requisite safeguards and systemic interventions necessary to protect the mental and behavioral health of these highly vulnerable groups.

One of the most significant omissions in the report is its failure to provide an explicit and comprehensive focus on the compounded challenges faced by LGBTQIA youth. These challenges are exacerbated by a growing wave of legislative actions that undermine their rights, coupled with an ongoing lack of protective measures within both educational and mental health frameworks. According to data from The Trevor Project, nearly 50% of LGBTQIA youth have seriously contemplated suicide within the past year, and an alarming 60% of these individuals were unable to access essential mental health care. These stark statistics underscore the critical need for targeted, preventative, and responsive interventions that go beyond mere acknowledgment of these struggles. The provision of mental health care for LGBTQIA youth must be framed not as an afterthought, but as a central priority in the broader mental health discourse.

While the report acknowledges regional disparities and systemic barriers that hinder access to care, it fails to offer concrete solutions for the deeply entrenched structural

inequalities that disproportionately affect LGBTQIA youth. For example, the emotional and psychological toll of discrimination, bullying, and exclusion is not sufficiently addressed in the report. These experiences significantly affect the mental health of LGBTQIA students and contribute to a higher incidence of anxiety, depression, and suicidal ideation. Therefore, it is essential the report call for the development of policies that specifically include LGBTQIA -focused mental health services within school systems. Further, it must advocate for the establishment of safe, inclusive environments in which LGBTQIA students are able to seek mental health support without the threat of being outed or further marginalized by their peers or school staff.

In addition, the report highlights the lack of diversity among mental health service providers—an issue that is especially pertinent for LGBTQIA students who frequently encounter barriers to care due to a dearth of providers who are both culturally competent and LGBTQIA-affirming. The failure to address this gap is a critical oversight. It is not enough to simply encourage diversity among mental health professionals; it is paramount that the Commission call for the recruitment, training, and retention of mental health providers who are not only well-versed in cultural differences, but who also possess a deep understanding of the specific mental health needs of LGBTQIA youth. This is necessary to address the disproportionately high levels of distress and mental health struggles this population endures.

Equally troubling is the report's lack of focus on the intersectionality of race, ethnicity, gender identity, and mental health within the LGBTQIA student population. LGBTQIA youth of color, in particular, face compounded challenges that hinder their access to culturally competent and affirming care. The complexities of navigating multiple marginalized identities can create additional barriers to mental health services, particularly in rural and underserved communities. These intersectional challenges must be explicitly acknowledged and addressed in any future policy and funding initiatives. The report would be significantly strengthened by the inclusion of targeted measures to address these barriers, including the allocation of resources for programs that deliver culturally competent and LGBTQIA-affirming mental health services—particularly in regions where access to care is already limited.

While I fully acknowledge the importance of the findings in the Iowa Advisory Committee's report, it does not go far enough in addressing the specific needs of LGBTQIA youth within Iowa's K-12 schools. This issue is not only significant; it is paramount. The need to protect, support, and nurture the mental and behavioral health of LGBTQIA students cannot be overstated. These students are among the most vulnerable in our society, facing daily challenges that impact their mental, emotional, and social well-being.

It is our collective responsibility to ensure they receive not just the acknowledgment of their struggles, but the support, validation, and resources necessary for them to succeed and thrive.

I urge the Commission to revisit its recommendations and prioritize the protection, inclusion, and support of LGBTQIA students within the mental and behavioral health framework. These students require more than a passing mention of their struggles; they need a clear and unwavering commitment to systemic reform that actively safeguards their mental health and well-being. Failure to act on this imperative is not merely an oversight; it is a dereliction of duty to those students who are most at risk.

We must recognize the mental and behavioral health of LGBTQIA students is not a matter of secondary importance—it is a fundamental right that must be protected. To do so, we must take bold, decisive action to ensure that all students, regardless of sexual orientation, gender identity, or any other characteristic, feel safe, supported, and valued within our educational systems. This is not simply a matter of policy; it is a matter of justice and equity. We cannot afford to allow another generation of students to be left behind.

It is time to implement policies that are genuinely inclusive, compassionate, and transformative—policies that explicitly affirm and protect LGBTQIA students, ensuring every young person has the opportunity to grow, learn, and thrive free from fear and discrimination.

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